The Most Common MC+/Medicaid Billing Errors and How to Avoid Them

To help providers understand the meaning of the more common denial codes, refer to the list below of the most common MC+/Medicaid billing errors and solutions to correct each problem.

Reason for Denial	RA Remark Code	Claim Adjustment Reason Code	How to Prevent
Duplicate Claim	N111	CO18	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form. • Please allow 60 days for the Medicare/Medicaid crossover claim to appear on the RA before resubmitting the claim directly to Medicaid
Recipient Ineligible on Date of Service, or Recipient Number Not on File	N30 or M58	CO30 or CO31	Before providing services to the recipient: • Make a copy of red Medicaid or MC+ card. Use 8-digit DCN number on card to verify eligibility. • Verify eligibility by calling the Interactive Voice Response system at 1-800-392-0938, or through the Internet at www.emomed.com or through a Point of Service Terminal. Reference 3.3 of your provider manual located on this website for information on all these options.
Service Not Medicaid Covered	N174	OA96	• Many codes/modifiers changed with the implementation of the Health Insurance Portability and Accountability Act (HIPAA). Reference program specific manuals and bulletins located on this website for updates to assure you are billing with accurate codes. • Reference “fee schedules” on this website under Provider Information for coverage/pricing/restrictions information.

Reason for Denial	RA Remark Code	Claim Adjustment Reason Code	How to Prevent
Potential Other Insurance	MA92	OA22	Medicaid is payor of last resort. Private insurance must be billed prior to Medicaid. • Verify recipient eligibility. If Medicaid shows the recipient has private insurance, you will be given the insurance information and must bill the other insurance resource prior to Medicaid. • Any information entered in the insurance fields 4, 7, 9-9d and 11-11d of the HCFA-1500 claim form when the recipient has no other insurance, may cause your claim to deny if there is no other insurance payment shown or an insurance denial attached to the claim.
Medicare Suspect	N59	CO22	Medicaid is secondary payor to Medicare. Verify recipient eligibility. If Medicaid shows the recipient has Medicare or the patient is 65 years of age or older, you must bill Medicare first.
Primary or Detail Diagnosis Invalid	MA63	CO47	Use diagnosis codes from the International Classification of Diseases 9th Revision Clinical Modification (ICD.9.CM). Some codes require 4 and 5 digits. Be sure to code to the highest level of specificity.
Claim Exceeds 12-month Filing Limit	N59	CO29	The Division of Medical Services must receive claims within 12 months from the date of service. Claims originally submitted timely that were denied or returned to the provider must be resubmitted and received within 24 months of the date of service.
Quantity Billed Over Limit	N59	COB5	This denial occurs when the quantity exceeds the maximum allowed by Medicaid. Refer to the pricing file on this website to determine the maximum quantity for specific procedure codes. If medically necessary, Medicaid may cover more than the maximum quantity. Providers should bill codes on separate lines of a paper claim form and attach notes.

Reason for Denial	RA Remark Code	Claim Adjustment Reason Code	How to Prevent
Provider Ineligible on Date of Service	M57	COB7	New providers cannot bill for services provided before Medicaid enrollment begins. If there is a question of eligible/ineligible dates, please contact the Provider Enrollment Unit via email at providerenrollment@mail.medicaid.state.mo.us.
Optical Character Recognition Scanning Errors			Efforts should be taken to submit HIPAA-compliant electronic claims. If claims have to be submitted in paper form, please adhere to the following: • Make sure your printer ribbon/ink cartridge produces a very dark print to ensure readability when the image is scanned. • Properly align your claims in your printer. • Avoid stamping any extraneous information on the claim such as “Corrected Claim”, “Second Request”, etc. • Use free claim forms supplied by the Division of Medical Services. To order, download the order form from this website by clicking on “forms”, then click on ”forms request”. Complete the form and mail to the address shown on the form.